EVIDENCE-BASED PRACTICES USED BY MENTAL HEALTH PROVIDERS IN WASHINGTON STATE

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EXECUTIVE SUMMARY

In 2006, the Mental Health Division (MHD) contracted with the Washington Institute for Mental Illness Research and Training (WIMIRT) to conduct a statewide survey of mental health providers. The goal of the survey was to collect information about the utilization of Evidence-Based Practices (EBPs) in Washington State. Of 150 eligible mental health facilities, 67 completed the survey, yielding a 45% response rate. Selected findings include:

- Approximately three-fourths (78%) of the responding facilities were implementing at least one EBP and more than half (61%) were implementing more than one.
- Facilities are implementing fewer EBPs for children (35% offer at least one EBP for children) than for adults (67% offer at least one EBP for adults).
- The most frequently implemented EBPs for Adults were Family Psychoeducation (37%) and Integrated Treatment for Co-occurring Mental and Substance Abuse Disorders (36%).
- The most frequently implemented EBP for Children was Multisystemic Therapy (19%).
- Among those responding to the survey, Illness Management and Recovery services were provided to the greatest number of people (n=14,412), followed by Medication Management (n=13,744).
- With the exception of facilities implementing Supported Employment or Functional Family Therapy, less than half monitor program fidelity for the EBPs they currently provide.

- The most frequent barrier to EBP implementation, regardless of which specific EBP was examined, was “Financial”.

Implications of the current study include: 1) educating policy makers and clinicians about the importance of monitoring EBP fidelity and the potential cost-effectiveness of using EBPs; 2) investigating the factors responsible for successful EBP dissemination and implementation; and 3) exploring creative ways to combine resources from mental health, Medicaid, criminal justice, vocational rehabilitation, and other funding sources to support evidence-based services.

I. INTRODUCTION

Evidence-based practices, or EBPs, refer to practices and procedures for which there is consistent scientific evidence showing that they improve consumer outcomes (Drake, Goldman, Leff, et al., 2001). Although a variety of pharmacological and psychosocial interventions are available to treat most mental disorders, the extent to which EBPs are utilized in real world settings is limited (Gold, Glynn, and Mueser, 2006; Wang, Berglund, and Kessler, 2000).

Despite the gap between research and practice, the public mental health system is moving forward with EBP implementation. Both national and state mental health leaders are emphasizing the importance of providing services with demonstrated clinical effectiveness (Esenwein, Bornemann, Ellingson, Palpant, Randolph, & Druss, 2005) and states are now required to report the number of children and adults who receive EBPs to the Center for Mental Health Services (CMHS). According to information collected from 48 State Mental Health Agencies (SMHA), every state, including Washington, was offering at least one EBP in Fiscal Year 2004, and most were offering more than one (National Association of State Mental Health Program Directors Research Institute, Inc., 2004).

In order to gain a better understanding of EBP implementation in Washington State and to meet the Substance Abuse and Mental Health Services Administration (SAMSHA) reporting requirements, DSHS Mental Health Division (MHD) contracted with the Washington Institute for Mental Illness Research and Training (WIMIRT) to conduct an online survey that would collect the following information: 1) the number of facilities that currently implement or plan to implement EBPs for children and adults; 2) the number of individuals that receive EBPs; 3) the number of facilities that are measuring EBP fidelity; and

4) barriers to EBP implementation. Ten SAMHSA supported EBPs were the major focus of this report. They are:

- Assertive Community Treatment (ACT)
- Supported Employment
- Supported Housing
- Family Psycho-education
- Integrated Treatment for Co-occurring Disorders
- Illness Management/Recovery
- Medication Management
- Multisystemic Therapy (MST)
- Therapeutic Foster Care
- Functional Family Therapy (FFT)

II. METHOD

Survey Design

The survey consisted of 57 questions (see Appendix B), 14 of which were adapted from the State Mental Health Agency Profiles System developed by the NASMHPD Research Institute (NRI). The purpose of the survey was to gather the following pieces of information:

A) The Number of EBP Programs. Respondents were asked to indicate whether their facility currently implements or is planning to implement each of the 10 EBPs listed above. They were also asked about other innovative or promising practices they are currently implementing.

B) The number of children and adults receiving EBPs. As part of SAMHSA's Uniform Reporting System (URS), MHD is required to provide information on the number of children and adults who receive EBPs. To satisfy this requirement, each respondent was asked to report the number of children and adults who

received each EBP in Fiscal Year 2005.

C) EBP Fidelity. A number of studies have shown that fidelity, or the degree to which an intervention is provided as intended, is associated with better client outcomes (McHugo, G.J., Drake, R.E., Teague, G.B., & Xie, H., 1999). Therefore, respondents were asked whether their facility measures program fidelity for the EBPs they currently provide. In addition, in order to fulfill federal block grant reporting requirements, a set of pilot questions was developed to assess whether facilities are satisfying EBP fidelity requirements as outlined by the Data Infrastructure Grant (DIG) Coordinating Center.

D) Barriers to EBP Implementation. Respondents were asked to identify any barriers to implementing each EBP.

Data Collection Procedures

The field period for this survey ran from March, 2006 to June, 2006. Prior to conducting the survey, MHD gave WIMIRT a list of 200 community inpatient and outpatient mental health facilities in Washington State. The list included the name and address of each facility as well as the name and phone number of the facility administrator. In late February 2006, the facility administrator at each agency was sent a letter alerting them to expect two surveys: one examining the utilization of EBPs and the other examining the treatment of co-occurring disorders (Appendix A). The letter included a request to e-mail, fax, or phone WIMIRT with the name and phone number of a contact person who would be most appropriate to complete the survey.

If the facility administrator did not respond to this request, they were telephoned and asked to provide contact information. Once contact information was obtained, the following steps were taken to collect survey data:

1) First, the contact person was e-mailed a letter informing them that they would be receiving the survey (see Appendix A).

2) One to two weeks after the initial email, the contact person was sent a cover letter with instructions on how to complete the survey (see Appendix A). A Microsoft Word copy of the survey was attached to each email. The contact person was informed that he or she could respond to the survey using one of three methods: by web-based data entry; by US mail; or by sending it to WIMIRT as an email attachment. To limit web-based data entry only to those in the sample, each facility was given a custom ID. The contact person was instructed to complete the survey within 2 weeks of receiving the cover letter.

3) If the contact person did not complete the survey, they were sent a reminder/thank you email 2 to 4 weeks after receiving the cover letter email.

4) If the contact person still did not complete the survey, they were telephoned and either asked to complete the survey or, if unavailable, they were left a voice mail message to complete the survey.

Respondents

Survey participation was voluntary. Of the 200 facilities that were in the survey universe, 10 facilities only provided crisis services and were excluded from the sample. Nineteen facilities were found to be ineligible to take the survey because they were either closed or were not providing direct mental health services. An additional 21 facilities were "rolled into" other facilities counts and therefore were not reported separately. These were facilities that managed satellite facilities and reported facility characteristics and client counts for their own facility and for other facilities. This left 150 facilities that were eligible to participate.

Of 150 eligible facilities, eight facilities had incorrect contact information (either phone numbers or addresses) and could not be located on the internet (see Table 1). Twenty-one facilities would not give WIMIRT contact information

regarding who should fill out the survey and therefore were considered refusals. Despite email and telephone prompting, staff at 54 facilities did not complete the survey, and were given a "No Response" disposition. The survey was completed by staff at 67 facilities, yielding a response rate of 45%. Three facilities (4%) returned the survey via mail, 15 facilities (22%) returned the survey via e-mail, and the remaining 49 facilities (73%) completed the survey online. The majority of respondents identified themselves as Program/Clinical Directors but the sample also included Chief Executive Officers (CEO), Vice Presidents, and Clinical Supervisors/Therapists.

Table 1: Dispositions of the Sample

	N	%
Incorrect number/address	8	5
Refusal	21	14
No Response	54	36
Complete	67	45
Total	150	100%

III. RESULTS

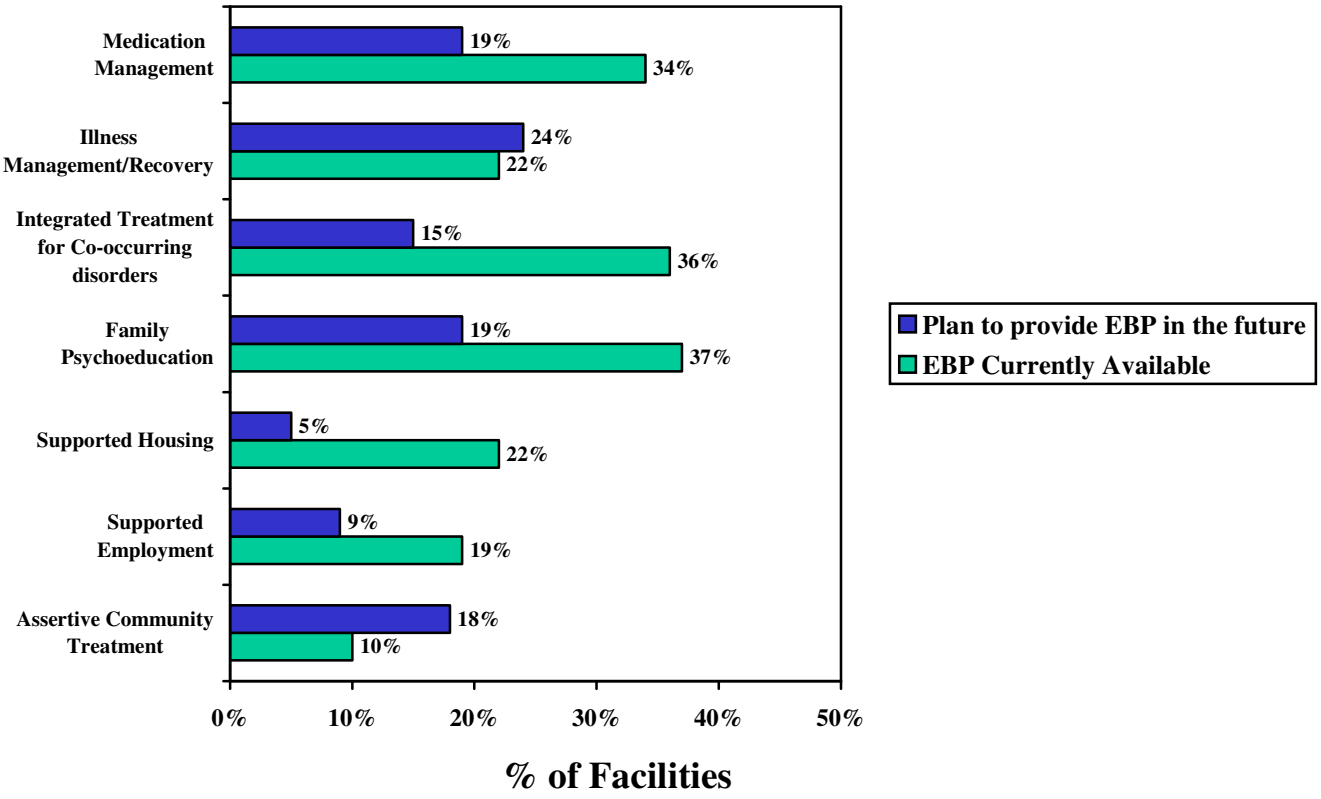
A. Number of EBP Programs

Overall, seventy-eight percent (n = 52) of the facilities reported providing at least one of the 10 EBPs listed above and 61% (n = 41) indicated that they are implementing two or more EBPs.

Adults. The percentage of reporting facilities that are implementing or planning to implement adult EBPs is presented in Figure 1. It should be noted that

facilities planning to implement a particular EBP are different from facilities that are currently implementing that EBP. Information about whether a facility will continue to provide each EBP in the future was not collected.

Figure 1: Percent of Reporting Mental Health Facilities Implementing or Planning to implement Adult EBPs, N = 67



Taken as a whole, 64 percent (n=43) of the surveyed facilities indicated that they are currently implementing at least one adult EBP. The three most frequently implemented adult EBPs were Family Psychoeducation (37% of the sample; n=25), Integrated Treatment for Co-occurring Disorders (36%; n=24), and Medication Management (34%; n=23).

Approximately one-fifth of the facilities reported that they currently implement Supported Housing (22%; n=15), Illness Management and Recovery (n=15; 22%), and Supported Employment (19%; n=13). The least commonly implemented adult EBP was Assertive Community Treatment (10%; n=7).

The mental health facilities reported similar trends in relation to future plans for implementation. Approximately one-fourth to one-fifth of the facilities have plans to implement Illness Management and Recovery (24%; n=16), Family Psychoeducation (19%; n=13), Medication Management (19%; n=13), and ACT (18%; n=12) services in the future. Fifteen percent of the facilities have plans to implement Integrated Treatment for Co-occurring Disorders. Less than 10 percent of the reporting facilities have plans to implement Supported Housing (5%; n=3) or Supported Employment (9%; n=6) services.

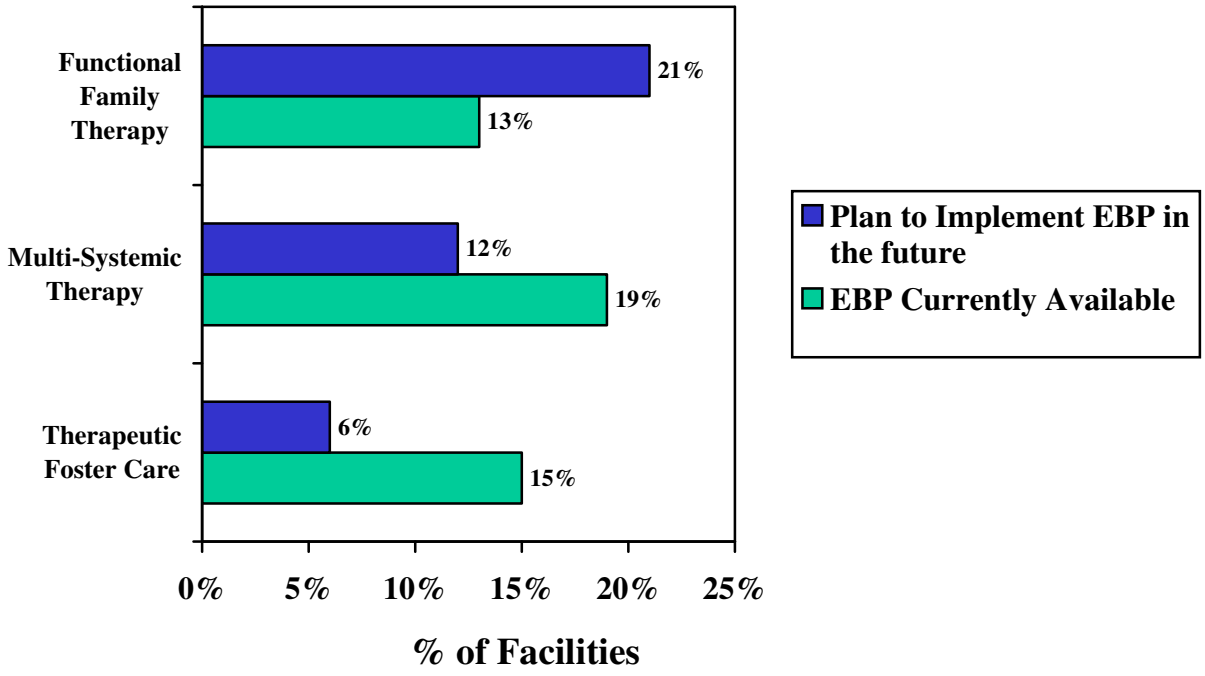
When asked about other EBPs or promising practices the facility was implementing or planned to implement in the future, the most common response was Dialectical Behavior Therapy or (12%; n=8), followed by Cognitive Behavior Therapy (8%; n = 5). Fewer than 5% of the respondents mentioned other EBPs or promising practices.

Children. The percent of reporting facilities implementing or planning to implement EBPs for children is presented in Figure 2. Overall, fewer facilities are offering EBPs for children than for adults. Thirty-five percent (n=25) of the 67 facilities indicated they are currently administering any of the EBPs for children. Nineteen percent of the facilities (n=13) are implementing Multisystemic Therapy, 15 percent (n=10) are implementing Therapeutic Foster Care, and 13 percent (n=9) are implementing Functional Family Therapy.

The highest percent of facilities (21%) have plans to implement Functional Family Therapy in the future, followed by Multisystemic Therapy and Therapeutic Foster Care.

When asked about other children's EBPs or promising practices the facility was implementing or planned to implement in the future, the most common response was Cognitive Behavior Therapy (15%; n= 10), followed by Dialectical Behavior Therapy (9%; n = 6) and Wraparound Services (4%;n=3).

Figure 2: Percent of Mental Health Facilities Implementing or Planning to Implement Children's EBPs, N=67

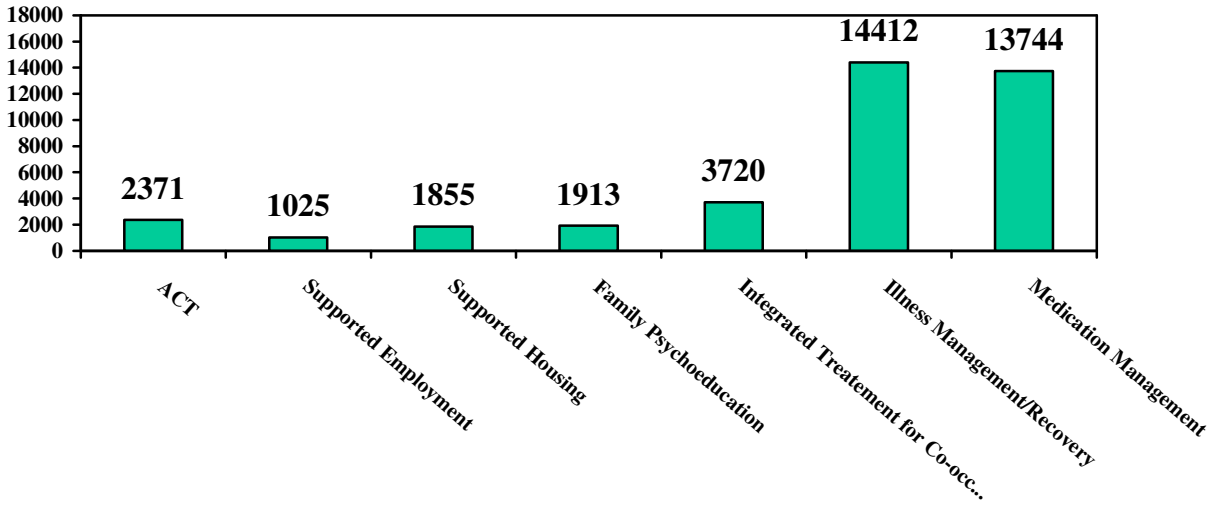


B. Number of individuals who received EBPs in the Surveyed Facilities.

Adults.

The number of adults that received each EBP *in the surveyed facilities*[1] during FY2005 is presented in Figure 3. Illness Management and Recovery services were provided to the most number of people (n=14,412)[2], followed by Medication Management (n=13,744), Integrated Treatment for Co-occurring Disorders (n=3,720), Assertive Community Treatment (n=2,371), Family Psychoeducation (n=1,913), and Supported Housing (n=1,855). Among the adult EBPs, the fewest number of consumers received Supported Employment services (n=1,025).

Figure 3: Number of Adults Receiving EBPs in the Surveyed Sites



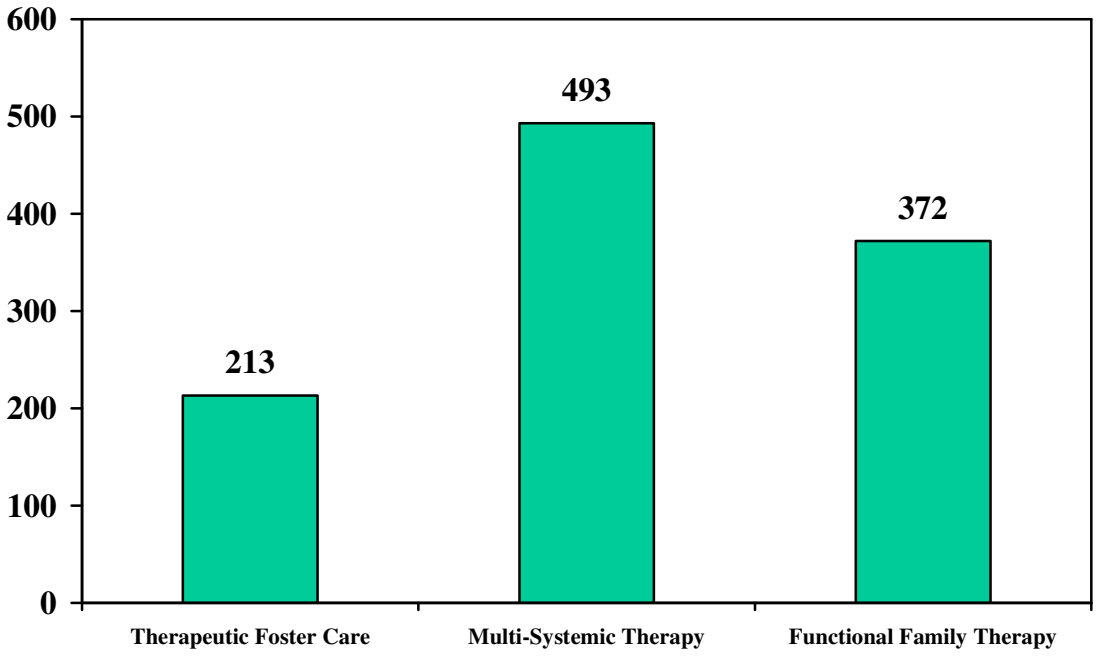
[1] The numbers represent only those consumers receiving evidence-based practices within the 67 surveyed sites. It does not include all of those receiving services throughout the State of Washington. It should also be noted that these numbers are not restricted to only persons with serious mental illness.

[2] One of the facilities (within King County) accounted for 76% of the consumers provided with this EBP (n=11,011).

Children

The number of children *in the surveyed facilities* that received Multisystemic Therapy, Therapeutic Foster Care, and Functional Family Therapy during FY2005 is presented in Figure 4. Similar to the difference in the number of facilities that are implementing adult compared with child EBPs, the number of children receiving EBPs is substantially less than the number of individuals receiving adult EBPs. Specifically, mental health facilities reported that 493 children received Multisystemic Therapy (n=493), followed by Functional Family Therapy (n=213), and Therapeutic Foster Care (n=213).

Figure 4: Number of Children Receiving EBPs in the Surveyed Sites, FY2005



C. EBP Fidelity

All facilities who responded to the survey were asked to indicate whether they measured program fidelity for the EBPs they currently provide (see Figure 5). In addition, to help assess whether minimum DIG reporting requirements are being met, a set of pilot questions were developed for nine of the 10 EBPs. Responses to individual questions for each EBP are presented in Appendix C. Because the Washington Institute was simultaneously administering another provider survey examining the integrated treatment of co-occurring disorders during the administration of the current survey, pilot questions were not developed to assess the fidelity of Integrated Treatment for Co-occurring Disorders (MH/SA).

Assertive Community Treatment (ACT). Of the seven facilities that said they were currently offering ACT services, two (29%) reported that they measure ACT program fidelity (Figure 5).

The responses to the pilot questions used to determine whether a program meets SAMHSA's requirements for reporting ACT were as follows:

- Small Caseload: The average provider to client ratio was 1:8, and ranged between 1:4 and 1:15. Four out of seven facilities (57%) reported a provider to client ratio of 1 to 10 or fewer.
- Multidisciplinary Team Approach. Six (86%) facilities indicated that they emphasized a team approach "All of the Time" or "Most of the Time" rather than an approach that emphasized services by individual providers. Three (43%) facilities had at least 3 FTEs on the ACT team.
- Services Provided in Community Settings. When asked "to what degree does your ACT program develop living skills in the community rather than in the office", five (72%) facilities indicated "All of the Time" or "Most of the Time". Only one facility said they develop living skills in the community "Not at All".

- Includes Clinical Component. Six out of seven of the facilities (86%) said that their ACT program provides substance abuse treatment services. Five (71%) provide psychiatric services, counseling/psychotherapy services, and housing support services. Four facilities (57%) reported that they provide employment rehabilitation services. A psychiatrist was a member of the ACT treatment team at five (71%) of the facilities, as were nurses and substance abuse specialists. A case manager was on the ACT team at six (86%) of the facilities. Three (43%) of the reporting facilities indicated that a vocational specialist or a peer support specialist was a member of their treatment team.
- Responsibility for Crisis Services. Six (86%) of the facilities indicated that their ACT teams had 24-hour responsibility for psychiatric emergencies.

Two of the seven facilities (29%) met DIG criteria for reporting ACT services by: 1) having a small caseload (ie. provider to client ratio of 1:10 or fewer); 2) providing services in the community rather than the office "Most of the Time" or "All of the Time"; 3) providing 24 hour crisis services; 4) including a clinical component, in addition to case management; AND 5) using a multidisciplinary team approach. For the two facilities that met DIG criteria, 14 consumers received ACT services in FY2005.

Supported Employment. Of the 13 facilities currently providing Supported Employment services, eight (62%) indicated that they measure program fidelity (Figure 5).

The responses to the pilot questions used to determine whether a program meets SAMHSA's requirements for reporting Supported Employment were as follows:

- Competitive employment. Ten (77%) of the 13 facilities indicated that their employment specialists provide competitive job options

in normalized settings where clients work side by side with employees hired from the general population "Most of the Time" or "All of the Time."

- Integration with Treatment. Ten (77%) of the facilities indicated that their employment specialists attend regular treatment meetings "Most of the Time" or "All of the Time". Eleven (85%) of the 13 facilities reported that their employment specialists have frequent contact with treatment team members "Most of the Time" or "All of the Time."
- Rapid Job Search. Nine (69%) indicated that it typically takes 1-6 months before a consumer makes their first contact with an employer.
- Eligibility based on consumer choice (not client characteristics). Nine (69%) facilities indicated that no criteria are used to determine whether a person is eligible for supported employment services.

Seven (54%) of the 13 facilities met DIG criteria for reporting Supported Employment services by: 1) offering competitive job options; 2) being integrated with treatment; and 3) lacking inclusion criteria for eligibility. For the seven facilities that met DIG criteria, 704 consumers received Supported Employment services in FY2005.

Supported Housing. Of the 15 facilities currently providing Supported Housing services, three (23%) reported that they measure program fidelity (Figure 5).

The responses to the pilot questions used to determine whether a program meets SAMHSA's requirements for reporting Supported Housing were as follows:

- Target Population. Thirteen (87%) facilities indicated that Supported Housing services are provided to persons who would not

be in an independent living situation without this service, "All of the Time" or "Most of the Time".

- Staff Assigned. Twelve (80%) facilities indicated that specific staff are assigned to provide Supported Housing services.
- Housing is Integrated. Eleven (73%) of the facilities reported that Supported Housing consumers are living in integrated settings "All of the Time" or "Most of the Time".
- Consumer has right to Tenure. When asked to what extent the consumers in the Supported Housing programs have ownership or lease documents in their name, 11 (73%) of the respondents indicated "All of the Time" or "Most of the Time".
- Affordability. When asked what percentage of housing costs (rent and utilities) consumers typically pay for, 20 percent of the respondents indicated 0-20%, 47 percent indicated 21-39%, 27 percent indicated 40-59%, and 6 percent indicated 80% or more.

Five (33%) of the fifteen facilities met DIG inclusion criteria for reporting Supported Housing services by: 1) targeting persons who would not be in an independent living situation without this service; 2) having specific staff assigned to provide Supported Housing services; 3) providing integrated living situations; 4) offering consumers the right to tenure; and 5) offering affordable services. For the five facilities that met DIG criteria, 992 consumers received Supported Housing services in FY2005.

Family Psychoeducation. Of the 25 facilities that provide Family Psychoeducation, only two (8%) indicated that they currently measure Family Psychoeducation program fidelity (Figure 5).

The responses to the pilot questions used to determine whether a program meets SAMHSA's requirements for reporting Family Psychoeducation were as follows:

- Structured Curriculum. Eight of the facilities (32%) provide Family Psychoeducation using a standard curriculum. Fifteen (60%) of the 25 facilities that provide Family Psychoeducation teach families problem solving skills "Most of the Time" or "All of the Time". When asked to what extent families are taught to identify early warning signs and symptoms of relapse, 18 (72 %) indicated "Most of the Time" or "All of the Time". Similarly, 18 (72%) indicated that families were taught to identify precipitating factors that may lead to a relapse "Most of the Time" or "All of the Time."

Eight of the facilities (32%) met DIG inclusion criteria for reporting Family Psychoeducation by providing this treatment using a standard curriculum. These eight facilities provided Family Psychoeducation services to 250 individuals in FY2005.

Integrated Treatment for Co-occurring Disorders. Of the 24 facilities that currently provide this EBP, 10 (42%) measure the fidelity of their Integrated Treatment for Co-occurring disorder programs (Figure 5). These nine facilities reported providing Integrated Treatment for Co-occurring Disorders to 2,800 individuals in FY2005.

Illness Management and Recovery (IMR). Of the 15 facilities that provide Illness Management and Recovery (IMR) services, four (27%) measure program fidelity (Figure 5).

The responses to the pilot questions used to determine whether a program meets SAMHSA's requirements for reporting IMR were as follows:

- Structured Curriculum. Seven (47%) facilities indicated that they provided Illness Management and Recovery services using a structured curriculum. Of the programs that did use a structured curriculum, all provided information about 'recovery strategies',

'practical facts about mental illness and treatment', 'effective use of medication', and ' coping with stress'.

Seven (47%) of the 15 facilities met DIG inclusion criteria for reporting IMR services by using a structured curriculum which includes information about mental illness facts, recovery strategies, using medications and stress management and coping. These seven facilities reported providing IMR services to 2,589 individuals in FY2005.

Medication Management. Of the 23 facilities that indicated they currently provide Medication Management, eight (33%) measure program fidelity (Figure 5).

The responses to the pilot questions used to determine whether a program meets SAMHSA's requirements for reporting Medication Management were as follows:

- Treatment Plan Specifies Outcome for Each Medication. Fifteen (65%) facilities indicated that the Medication Management treatment plan specifies what outcome is expected for each outcome "Most of the Time" or "All of the Time."
- Desired Outcomes are Tracked Systematically. Fifteen facilities (65%) indicated that consumer responses to each medication are recorded using standardized forms and charts
- Sequencing of Anti-psychotic Medications are Based on Clinical Guidelines. Fifteen facilities (65%) also indicated that anti-psychotic medication changes were based on clinical guidelines "Most of the Time" or "All of the Time."

Eight (35%) of the 23 facilities met DIG inclusion criteria for reporting Medication Management services. These eight facilities reported providing Medication Management services to 9,132 individuals in FY2005.

Multisystemic Therapy (MST). Of the 13 facilities that reported providing MST services, 5 (39%) monitor program fidelity (Figure 5).

The responses to the pilot questions used to determine whether a program meets SAMHSA's requirements for reporting MST were as follows:

- Services are Provided by MST therapists or Masters level Professionals. Twelve (92%) indicated that MST services were provided by either MST therapists or Masters level professionals.
- Services are available 24/7. Six (46%) indicated that MST services were available 24/7.
- Services are Time-limited. Nine (69%) of the facilities indicated that their MST programs were time-limited.
- Services take into account the life situation and environment of the child. Ten (77%) of the MST programs provide parents with the resources needed for effective parenting "Most of the Time" or "All of the Time." Nine (69%) of the programs attempt to decrease youth involvement with delinquent and drug using peers "Most of the Time" or "All of the Time." Ten (77%) of the MST programs attempt to increase youth association with prosocial peers "Most of the Time" or "All of the Time."

Five (38%) of the facilities met DIG criteria for reporting MST services by 1) providing MST services with MST or Masters level therapists; 2) providing the services 24/7; 3) providing time limited services; and 4) taking into account the life situation of the child. These five facilities reported providing MST services to 103 children in FY2005.

Therapeutic Foster Care. Of the 10 facilities currently providing Therapeutic Foster Care, two (20%) indicated that they monitor program fidelity (Figure 5).

The responses to the pilot questions used to determine whether a program meets SAMHSA's requirements for reporting Therapeutic Foster Care were as follows:

- A Program Is In Place to Train and Supervise Treatment Foster Parents. All of the Therapeutic Foster Care programs indicated that they provide training to foster parents "Most of the Time" or "All of the Time." Similarly, all said they provide ongoing supervision and support to the foster parents "Most of the Time" or "All of the Time".

Ten of the facilities (100%) met DIG criteria for reporting Therapeutic Foster Care services by providing training and supervision to Therapeutic Foster Care parents. These 10 facilities reported providing Therapeutic Foster Care services to 213 children in FY2005.

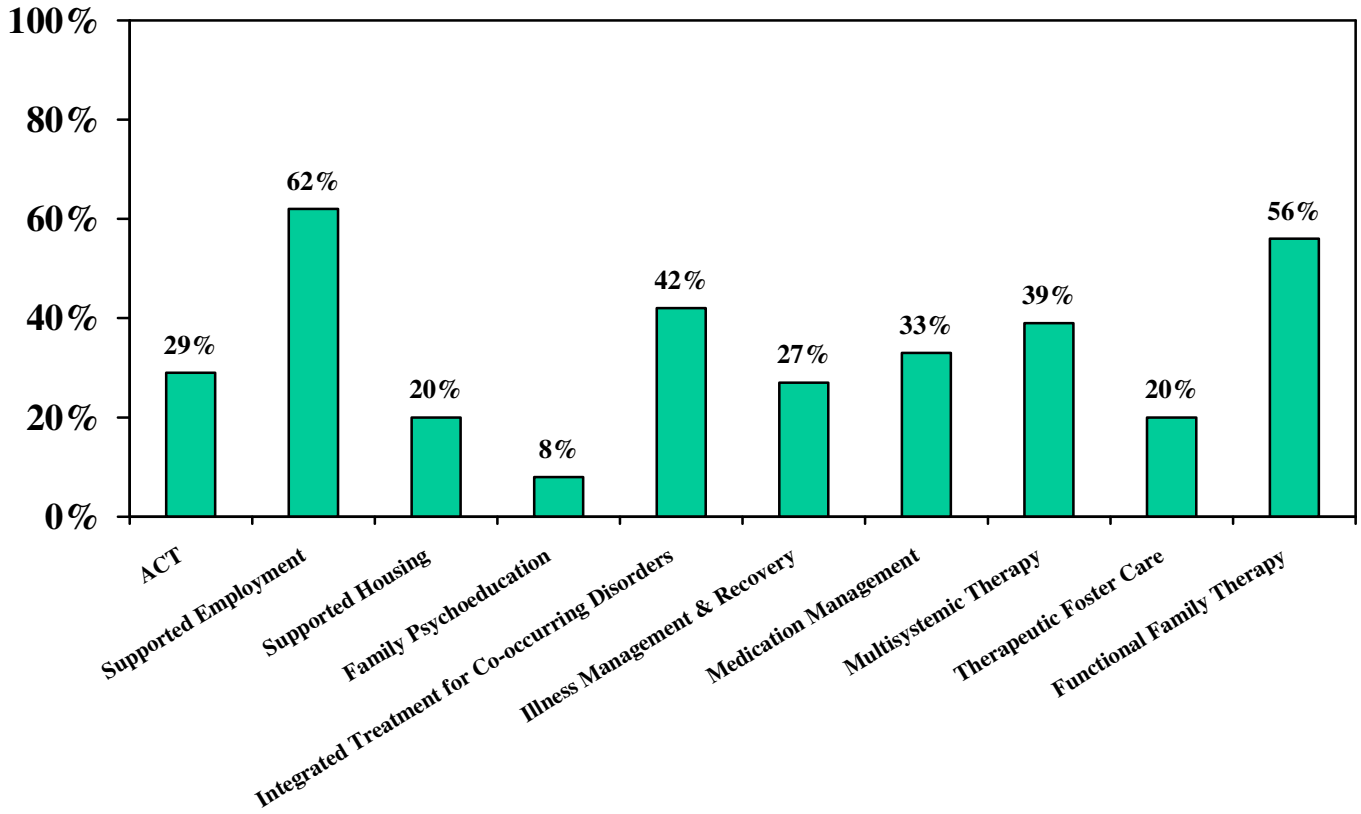
Functional Family Therapy (FFT). Of the nine facilities providing Functional Family Therapy, five (56 %) indicated that they monitor program fidelity (Figure 5).

The responses to the pilot questions used to determine whether a program meets SAMHSA's requirements for reporting Functional Family Therapy were as follows:

- Services are Provided in Phases. When asked whether they provide Functional Family Therapy in phases related to engagement, motivation, assessment, behavior change, and generalization, eight (89%) of the facilities responded "Most of the Time" or "All of the Time".
- Flexible Delivery of Services Provided in Multiple Settings. All of the nine facilities indicated that they provide services at the client's home. The next most common location for providing services was in a clinic setting (67%).

Eight of the nine facilities (89%) met DIG criteria for reporting Functional Family Therapy services by: 1) providing services in phases and 2) providing services in multiple settings. These eight facilities reported providing FFT services to 357 children in FY2005.

Figure 5: Percent of Facilities Measuring Program Fidelity by EBP *



* Percentages are of those facilities that are currently providing EBPs.

D. Barriers to Implementing EBPs

Respondents were asked to identify barriers to implementing each EBP (see Table 2). For each EBP, the most frequently reported barrier was "Financial". The second most frequently reported barrier for seven of the 10 EBPs was "Shortage of appropriately trained workforce". The least frequently reported barrier to implementing EBPs was "Resistance by clinicians."

Table 2 also shows that barriers are specific to each EBP. For instance, for Supported Housing, the shortage of appropriately trained workforce is not nearly as critical as financial barriers. For other EBPs both are identified as critical (e.g., Integrated Treatment for Co-occurring Disorders).

Table 2: Barriers to EBP Implementation

	n	None	Financial	Modification of EBP model to fit local needs	Attaining and maintaining fidelity	Shortage of appropriately trained workforce	Resistance to implementing EBP by clinicians	Not Applicable
ACT	19	11%	90%	26%	21%	32%	0%	5%
Supported Employment	21	10%	67%	33%	24%	38%	0%	0%
Supported Housing	20	20%	80%	40%	30%	15%	0%	0%
Family Psychoeducation	37	16%	43%	38%	30%	35%	16%	3%
Integrated Treatment for Co-occurring Disorders	29	14%	69%	28%	17%	56%	10%	0%
Illness Management and Recovery	23	17%	52%	48%	35%	48%	9%	4%
Medication Management	34	27%	53%	24%	18%	41%	15%	3%
Multisystemic Therapy	22	9%	77%	50%	55%	50%	9%	5%
Therapeutic Foster Care	17	12%	82%	47%	24%	41%	0%	12%
Functional Family Therapy	20	10%	80%	35%	30%	50%	10%	5%

IV. DISCUSSION

This report describes an exploratory effort to assess the utilization of EBPs in Washington State. Data were collected from community inpatient and outpatient mental health facilities through the use of a survey. Sixty-seven of 150 eligible mental health facilities completed the survey, yielding a response rate of 45 percent.

Results showed that approximately three-fourths of the reporting facilities were providing at least one EBP, and more than half were providing more than one. Of the seven adult and three child EBPs examined, a greater proportion of the facilities were providing EBPs developed for adults than children (67% offer at least one EBP for adults; 35% offer at least one EBP for children). This is perhaps not surprising given that over twice as many adults are served by the mental health system than are children. The most frequently implemented adult EBP was Family Psychoeducation and the least frequently implemented adult EBP was Assertive Community Treatment (ACT). The most frequently implemented EBP for Children was Multisystemic Therapy. Among the reporting facilities, more people received Illness Management and Recovery (n=14,412) services in fiscal year 2005 (FY2005) than any other EBP EBPs designed for children were provided to 1,078 people by the surveyed facilities in FY2005.

With the exception of Supported Employment and Functional Family Therapy, less than 50 percent of the surveyed facilities monitor EBP program fidelity. Similarly, for the majority of EBPs, less than 50 percent of facilities met DIG inclusion criteria for reporting EBP services. This is potentially problematic since many studies have shown that greater adherence to EBP principle components (i.e., fidelity) result in better client outcomes (Becker, Xie, McHugo, Halliday, and Martinez, 2006; Gowdy, Carlson, & Rapp, 2003; McGrew, Bond, Dietzen, and Salyers, 1994). It appears that although most facilities are providing at least

one EBP, in most cases it cannot be determined whether the EBPs are being implemented as described in the treatment literature.

Respondents believe that, regardless of which EBP was examined, the most frequent barrier to EBP implementation was financial, followed by a "shortage of an appropriately trained workforce." If facilities can overcome these barriers and further implement EBPs, future cost savings may be realized, if not for each facility, but for the mental health system in general. A recent meta-analytic review conducted by the Washington Institute for Public Policy (Aos, Mayfield, Miller & Wei Yen, 2006) found that not only do evidence based practices reduce the incidence and severity of serious mental illness, there are also significant savings per dollar of investment. They link these cost-benefits to fewer health care costs, reduced effects on the person's economic earnings in the job market, and lowered costs due to crime.

As with any project, results must be interpreted in light of procedural considerations and data limitations. The most critical limitation of the current project is potential sample bias. More specifically, less than 50 percent of the eligible sample responded to the survey. The low response rate is probably due to a variety of factors, not the least of which was the considerable time and effort required on the part of facility staff to complete the survey (e.g., contacting information systems staff to get the number of persons receiving each of the EBPs in FY2005). Moreover, we do not have information that allows us to determine the "representativeness" of the data that was collected. Hence, the relatively low response rate and lack of information to test representativeness calls into question whether the results can be generalized to Washington State mental health facilities as a whole.

In the future, methods of data collection for provider surveys should be changed to increase response rates. We recommend including MHD, and perhaps RSN-specific, letters of endorsement. In addition, information should be identified

and collected that allows us to assess how representative the collected data are to the provider population in general.

Another limitation has to do with the relatively high percentage of "missing data" with some of the items. This was especially true of items that required a check "yes" if affirmative and "no" if negative. Many of these items were simply left unchecked. The instrument needs to be revisited to eliminate or reduce the potential for missing data.

With the exception of Family Psychoeducation, less than 20 respondents answered the pilot questions for each EBP. The low response rate is partly due to the small number of facilities providing each EBP, but may also be related to the wording of individual questions (i.e., the respondent did not understand what a question was asking and therefore did not complete it). The pilot questions for each EBP need to be reconsidered.

Implications of the current study include: 1) educating policy makers and clinicians about the cost-effectiveness of EBPs and the importance of monitoring EBP fidelity, 2) investigating the factors responsible for successful EBP dissemination and implementation; and 3) exploring creative ways to combine resources from mental health, Medicaid, criminal justice, vocational rehabilitation, and other funding sources to support evidence-based services.

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Appendix A

Letters and Emails Sent to Providers

NOTIFICATION LETTER TO AGENCY ADMINSTRATORS

February 24, 2006

«Administrator»
«Agency»
«Streetaddress»
«City», «State» «Zipcode»

PROVIDER SURVEYS

As you know, there has been increased attention in the public mental health system on evidence-based practice (EBP) models and co-occurring mental and substance use disorders. In order to better understand these important issues, the Mental Health Division (MHD) has contracted with the Washington Institute to administer two web-based surveys.

The first survey focuses on the extent to which mental health facilities in Washington State utilize EBPs. Your answers will be used to fulfill MHDs federal requirements for reporting the number of children and adults who receive EBPs and will provide stakeholders with information about the barriers associated with adopting and implementing EBPs in Washington State. The purpose of the second survey is to better understand the work force capacity of mental health facilities in providing services to persons with co-occurring disorders. Information collected from this survey will be used to assist in planning for training and implementation of Senate Bill 5763.

REQUEST FOR CONTACT INFORMATION
Please provide us with contact information about the individual(s) whom is best suited to complete the 1) EBP survey, and 2) the Co-Occurring Disorders survey—if it is the same individual just report "Same." Although the Clinical Director of your facility might be best able to complete the surveys, any designee with extensive knowledge about EBP and/or co-occurring disorder programs at your facility would be appropriate. Once we receive this information we will contact them with next steps for completing the two surveys. RSN administrators have already been notified about the surveys.

Simply complete the table below and send the contact information to Bill Voss via telephone (253-761-7594), FAX (253-756-3987) or e-mail, bvoss15@u.washington.edu by March 8, 2006.

SURVEY	CONTACT PERSON	PHONE	E-MAIL
Evidence-Based Practices			
Co-Occurring Disorders			

Thank you for your assistance. We look forward to working with you on these exciting projects.

William D. Voss, PhD
Research Associate
University of Washington, Department of Psychiatry and Behavioral Sciences
Washington Institute for Mental Illness: Research and Training (WIMIRT), Western Branch

PRE-NOTIFICATION E-MAIL TO AGENCY CONTACT PERSON

Dear Colleague,

In the next couple days you will receive an email requesting that you fill out a web-based survey for an important research project being conducted by the Washington Institute for Mental Illness: Research and Training (WIMIRT).

The survey concerns the utilization of evidence-based practices (EBPs) in Washington State.

We are writing to you in advance because we have found that people often like to know ahead of time that they will be contacted. This study is an important one and will be used to meet federal reporting requirements regarding the use of EBPs as well as identify barriers to EBP adoption and implementation in Washington State.

Thank you for your time. It is only with the generous help from people like you that our system can continue to improve.

Sincerely,

William D. Voss, Ph.D.
Research Associate
Washington Institute for Mental Illness: Research and Training (WIMIRT)
(253) 761-7594

COVER LETTER/NOTIFICATION E-MAIL

Dear Colleague,

I am writing to ask for your help in completing a survey concerning the extent to which evidence-based practices (EBP) are being utilized in Washington State.

Information obtained from the survey will be used to fulfill the Mental Health Division's federal requirements for reporting the number of children and adults who receive EBPs and will provide stakeholders with information about the barriers associated with adopting and implementing EBPs in Washington State.

There are three ways to answer this survey:

1. Enter the data online:
   - First, go to the Washington Institute's website at http://depts.washington.edu/washinst/.
   - From the Washington Institute's main web page, left-click with your mouse on **"EVIDENCE-BASED PRACTICES" (EBP)** survey.
   - The last step is to enter your facility's custom ID number, which is: ###

2. Print out a copy of the survey (see attached Word document) and return it with your answers to:

   Bill Voss
   The Washington Institute for Mental Illness Research and Training (WIMIRT)
   9601 Steilacoom Blvd., S.W.
   Tacoma, WA 98498-7213

3. Fill out a copy of the survey and send it as an email attachment to: bvoss15@u.washington.edu

Please complete the survey by April 28th, 2006. If you have difficulties submitting data or have any questions or comments related to this survey, please contact the survey administrator: Bill Voss, phone: 253-761-7594, email: bvoss15@u.washington.edu.

Thank you for your time and effort. If you have any questions or comments, please do not hesitate to contact me.

Sincerely,

Bill Voss, Ph.D.
Research Associate
University of Washington, Department of Psychiatry and Behavioral Sciences
The Washington Institute for Mental Illness: Research and Training (WIMIRT)

THANK YOU/REMINDER EMAIL

Dear Colleague,

A couple weeks ago I sent out an email inviting you to participate in a survey regarding the use of evidence based practices (EBPs).

If you have already completed the survey, I want to thank you for participating. If you have not completed the survey, please do so as soon as possible. There are three ways you can respond to this survey:

1. Print out a copy of the survey (see attached Word document) and return it with your answers to:

> Bill Voss
> The Washington Institute for Mental Illness Research and Training (WIMIRT)
> 9601 Steilacoom Blvd., S.W.
> Tacoma, WA 98498-7213

2. Fill out a copy of the survey (see attached Word document) and send it as an email attachment to: bvoss15@u.washington.edu.

3. Enter the data online:
- First, go to the Washington Institute's website at http://depts.washington.edu/washinst/.
- From the Washington Institute's main web page, left-click with your mouse on **"EVIDENCE-BASED PRACTICES" (EBP)** survey.
- The last step is to enter your facility's custom ID number, which is: ###.

Should you have any questions or concerns, feel free to contact me (Bill Voss) at (253) 761-7594. Thank you for your cooperation.

Bill Voss

Appendix B

The Survey Instrument

Evidence-Based Practices in Washington State:

Survey of Mental Health Providers

INTRODUCTION:

Purpose: The purpose of this survey is to provide the Mental Health Division (MHD) and other stakeholders with information about the extent to which evidence-based practices (EBPs) are being used in Washington State. Survey results will also be used to identify barriers to implementing EBPs and to track our progress now and in the future.

Adult Evidence-Based Practice Definitions

The following definitions for evidence-based-practices are taken from SAMHSA's Data Infrastructure Grants: Guidelines for Reporting Evidence-Based Practices.

Assertive Community Treatment (ACT): A team based approach to the provision of treatment, rehabilitation and support services. ACT/PACT models of treatment are built around a self-contained multi-disciplinary team that serves as the fixed point of responsibility for all patient care for a fixed group of clients. In this approach, normally used with clients with severe and persistent mental illness, the treatment team typically provides all client services using a highly integrated approach to care. Key aspects are low caseloads and the availability of the services in a range of settings.

Supported Employment: Mental Health Supported Employment (SE) is an evidence-based service for persons with serious mental illness to promote rehabilitation and help them return to productive employment. SE programs use a team approach for treatment, with employment specialists responsible for carrying out all vocational services from intake through follow-along. Job placements are: community-based (i.e., not sheltered workshops, not onsite at SE or other treatment agency offices), competitive (i.e., jobs are not exclusively reserved for SE clients, but open to public), in normalized settings, and utilize multiple employers. The SE team has a small client: staff ratio. SE contacts occur in the home, at the job site, or in the community. The SE team is assertive in engaging and retaining clients in treatment, especially utilizing face-to-face community visits, rather than phone or mail contacts. The SE team consults/works with family and significant others when appropriate. SE services are frequently coordinated with Vocational Rehabilitation benefits.

Supported Housing: Services to assist individuals in finding and maintaining appropriate housing arrangements. This activity is premised upon the idea that certain clients are able to live independently in the community only if they have support staff for monitoring and/or assisting with residential responsibilities. These staff assist clients to select, obtain, and maintain safe, decent, affordable housing and maintain a link to other essential services provided within the community. The objective of supported housing is to help obtain and maintain an independent living situation.

Supported Housing is a specific program model in which a consumer lives in a house, apartment or similar setting, alone or with others, and has considerable responsibility for residential maintenance but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities. Criteria identified for supported housing programs include: housing choice, functional separation of housing from service provision, affordability, integration (with persons who do not have mental illness), right to tenure, service choice, service individualization and service availability.

Family Psycho-education: Offered as part of an overall clinical treatment plan for individuals with mental illness to achieve the best possible outcome through the active involvement of family members in treatment and management and to alleviate the suffering of family members by supporting them in their efforts to aid the recovery of their loved ones. Family Psycho-Education programs may be either multi-family or single-family focused. Core characteristics of family Psycho-Education programs include the provision of emotional support, education, resources during periods of crisis, and problem-solving skills.

Integrated Treatment for Co-occurring Disorders (Mental Health/Substance Abuse): Dual diagnosis treatments combine or integrate mental health and substance abuse interventions at the level of the clinical encounter. Hence, integrated treatment means that the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in a coordinated fashion. In other words, the caregivers take responsibility for combining the interventions into one coherent package. For the individual with a dual diagnosis, the services appear seamless, with a consistent approach, philosophy, and set of recommendations. The need to negotiate with separate clinical teams, programs, or systems disappears. The goal of dual diagnosis interventions is recovery from two serious illnesses.

Illness Management/Recovery: Illness Self-Management (also called illness management or wellness management) is a broad set of rehabilitation methods aimed at teaching individuals with a mental illness strategies for collaborating actively in their treatment with professionals, for reducing their risk of relapses and rehospitalizations, for reducing severity and distress related to symptoms, and for improving their social support. Specific evidence-based practices that are incorporated under the broad rubric of illness self-management are psycho-education about the nature of mental illness and its treatment, "behavioral tailoring" to help individuals incorporate the taking of medication into their daily routines, relapse prevention planning, teaching coping strategies to managing distressing persistent symptoms, cognitive-behavior therapy for psychosis, and social skills training. The goal of illness self-management is to help individuals develop effective strategies for managing their illness in collaboration with professionals and significant others, thereby freeing up their time to pursue their personal recovery goals.

Medication Management: In the toolkit on medication management there does not appear to be any explicit definition of medication management. However the critical elements identified for evidence-based medication management approaches are the following:

1. Utilization of a systematic plan for medication management
2. Objective measures of outcome are produced
3. Documentation is thorough and clear
4. Consumers and practitioners share in the decision-making

Children and Adolescent Evidence-Based Practice Definitions:

Multi-systemic Therapy (MST): Multi-systemic Therapy (MST) is an intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior. The multi-systemic approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family, and extra-familial (peer, school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems. The goal is to facilitate change in this natural environment to promote individual change. The caregiver is viewed as the key to long-term outcomes.

Therapeutic Foster Care: Children are placed with foster parents who are trained to work with children with special needs. Usually, each foster home takes one child at a time, and caseloads of supervisors in agencies overseeing the program remain small. In addition, therapeutic foster parents are given a higher stipend than traditional foster parents, and they receive extensive pre-service training and in-service supervision and support. Frequent contact between case managers or care coordinators and the treatment family is expected, and additional resources and traditional mental health services may be provided as needed."

Functional Family Therapy: Functional Family Therapy (FFT) is an outcome-driven prevention/intervention program for youth who have demonstrated the entire range of maladaptive, acting out behaviors and related syndromes. Treatment occurs in phases where each step builds on one another to enhance protective factors and reduce risk by working with both the youth and their family. The phases are engagement, motivation, assessment, behavior change, and generalization.

1. Are you currently providing or planning to provide any of the following evidence based practices, as defined above, for adults? *(Please check all relevant cells)*

Evidence-Based Practice: *(see definitions above)*	**Services Currently Available**	**Not now available but plan to provide in the future**	**Not available and have no plans to provide in the future**
a. Assertive Community Treatment			
b. Supported Employment			
c. Supported Housing			

d. Family Psycho-education			
e. Integrated Treatment for Co-occurring disorders (MH/SA)			
f. Illness Management and Recovery			
g. Medication Management			
h. Other _____			

2. Are you currently providing or planning to provide any of the following evidence based practices, as defined above, for children/adolescents?
(Please check all relevant cells)

Evidence-Based Practice:	*Services currently available*	*Not now available but planning to provide in the future*	*Not available and have no plans to provide in the future*
a.Multisystemic Therapy (Conduct Disorder)			
b. Therapeutic Foster Care			
c. Functional Family Therapy			
d. Other: _____			

If your agency or facility currently provides one or more EBPs, please answer question 3.

If your agency does not provide ANY EBP, please skip to question 8.

3. Does your agency or facility have the capacity to report the number of consumers who received the following EBPs?

Evidence-Based Practice: *(see definitions above)*	*Yes*	**No**	*Not applicable, we do not provide this EBP*
a. Assertive Community Treatment			
b. Supported Employment			

c. Supported Housing			
d. Family Psycho-education			
e. Integrated Treatment for Co-occurring disorders (MH/SA)			
f. Illness Management and Recovery			
g. Medication Management			
h. Multisystemic Therapy			
i. Therapeutic Foster Care			
j. Functional Family Therapy			

Please complete the following question only if your agency is providing any of the evidence based practices listed in the previous section.

Note: If your agency does not have the capacity to report this information, please skip to question 5.

4. If you are currently providing any of the evidence-based practices listed above, please provide the total number of persons served for each EBP in FY 2005 (July 1, 2004 – June 30, 2005)

	Number of Persons Served (FY 2005)
a. Assertive Community Treatment	
b. Supported Employment	
c. Supported Housing	
d. Family Psycho-education	
e. Integrated Treatment for Co-occurring Disorders (MH/SA)	
f. Illness management/recovery	
g. Medication Management	
h. Multi-systemic Therapy	
i. Therapeutic Foster Care	
j. Functional Family Therapy	
k. Other: _____	
l. Other: _____	

5. In this question, we are interested in whether your program assesses or monitors fidelity (i.e., a measure of how closely treatment is adhering to established standards).

For the evidence-based practices listed below, please select "Yes", "No" or "Not Applicable" for each item. Click "Yes" only if you measure or monitor fidelity according to some identified measure or practice standard, "No" if you provide the EBP service but do not monitor it, and "Not Applicable" if you do not provide that EBP service:

	Assess/Monitor Fidelity of program		Not Applicable
	Yes	No	
a. Assertive Community Treatment	☐	☐	☐
b. Supported Employment	☐	☐	☐
c. Supported Housing	☐	☐	☐
d. Family Psycho-education	☐	☐	☐
e. Integrated Treatment for Co-occurring Disorders (MH/SA)	☐	☐	☐
f. Illness management and recovery	☐	☐	☐
g. Medication management	☐	☐	☐
h. Multi-systemic Therapy	☐	☐	☐
i. Therapeutic Foster Care	☐	☐	☐
j. Functional Family therapy	☐	☐	☐
k. Other: _____	☐	☐	☐
l. Other: _____	☐	☐	☐
m. Other: _____	☐	☐	☐

6. Is training provided to your staff for the provision of evidenced-based services?

☐ Yes (if yes, continue to question 7)
☐ No (if no, skip to question 8).

7. What mechanisms are used to provide training to staff related to these evidence-based services? (Please check all that apply)

	NONE	Internal Staff	Collaboration with Universities	***Provider-to-provider training***	***Expert Consultants***	***Outside Accreditation*** (specify)	NOT APPLICABLE (Don't Provide EBP)
a. Assertive Community Treatment							
b. Supported Employment							
c. Supported Housing							
d. Family Psycho-education							
e. Integrated Treatment for Co-occurring Disorders (MH/SA)							
f. Illness management/recovery							
g. Medication Management							
h. Multi-systemic Therapy							
i. Therapeutic Foster Care							
j. Functional Family Therapy							
k. Other: _____							

Next, we are concerned about the barriers that you may be experiencing in providing evidenced based services.

8. In the table below, identify any barriers that you are encountering for each of the EBP's: (please select all that apply)

	None	Shortages of appropriately trained workforce	Financing Issues in paying for EBP	Modification of the EBP model to meet local needs	Attaining or Maintaining Fidelity to EBP model standards	Resistance to implementing EBP from clinicians	Not Applicable
a. Assertive Community Treatment							
b. Supported Employment							
c. Supported Housing							
d. Family Psycho-education							
e. Integrated Treatment for Co-occurring Disorders (MI/SA)							
f. Illness management/recovery							
g. Medication Management							
h. Multi-systemic Therapy							
i. Therapeutic Foster Care							
j. Functional Family Therapy							
k. Other: _____							
l. Other: _____							

Assertive Community Treatment (ACT)

The next series of questions asks about assertive community treatment (ACT). If your agency or facility provides ACT services, please answer the following questions. If your agency DOES NOT provide ACT services, please skip to question 16.

9. Our ACT program emphasizes a team approach rather than an approach that emphasizes services by individual providers.

- ☐ Not at all
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time
- ☐ Don't know

10. To what degree does your ACT program develop community living skills in the community rather than in the office.

- ☐ Not at all
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time
- ☐ Don't Know

11. Which of the following services are provided by your ACT team:

- ☐ psychiatric services
- ☐ counseling/psychotherapy
- ☐ housing support
- ☐ substance abuse treatment
- ☐ employment/rehabilitative services

12. Which of the following staff currently work on your ACT team (check all that apply)?

- ☐ Psychiatrist
- ☐ Nurse
- ☐ Substance Abuse specialist
- ☐ Vocational specialist
- ☐ Psychologist
- ☐ Case manager
- ☐ Social Worker
- ☐ Peer Support Specialist
- ☐ Other: _____

13. Does your ACT program have 24-hour responsibility for covering psychiatric crises of consumers who are receiving ACT services?

- ☐ Yes
- ☐ No

14. What is the average Staff to Client Ratio of your ACT team?

_____ Patients per ACT Team staff member.

15. How many full time staff are on your ACT team (s)?

_____ FTE

Supported employment

If your agency/facility provides supported employment, please answer the following questions. If your agency/facility does not provide supported employment services, please skip to question 20.

16a. Our employment specialists provide competitive job options in normalized settings where clients work side-by-side with employees hired from the general population.

- ☐ Not at all
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time
- ☐ Don't Know

16b. Our employment specialists provide job options in a variety of industries (i.e., clerical, technical, food service, etc).

- ☐ Not at all
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time
- ☐ Don't Know

17a. Our employment specialists attend regular treatment team meetings.

- ☐ Not at all
- ☐ Some of the time
- ☐ Most of the time

☐ All of the time
☐ Don't Know

17b. Our employment specialists have frequent contact with treatment team members.

☐ Not at all
☐ Some of the time
☐ Most of the time
☐ All of the time
☐ Don't Know

18. What is the typical length of time between when a person begins the supported employment program and their first contact with an employer?

☐ Within 1 month
☐ 1-6 months
☐ 7-9 months
☐ 10-12 months
☐ More than a year

19. What criteria, if any, are used to determine if a person is eligible for vocational services? (check all that apply)

☐ Job readiness
☐ Lack of substance abuse
☐ No history of violent behavior
☐ Mild psychiatric symptoms
☐ No criteria are used, all adult clients with severe mental disorders are eligible

Supported Housing

If your agency/facility provides supported housing services, please answer the following questions. ***If your agency/facility does not provide supported housing services, please skip to question 25.***

20. Are specific staff assigned to provide supported housing services at your agency?

☐ Yes
☐ No

21. To what extent is your supported housing program provided to persons who would not have a viable housing arrangement without this service?

- ☐ Not at all
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time
- ☐ Don't Know

22.To what extent are supported housing consumers living in facilities that are integrated (i.e., the consumer is living with or around people who do not have a mental disorder):

- ☐ Not at all
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time
- ☐ Don't Know

23. To what extent do consumers have the ownership or lease documents of the house, apartment, or similar setting in their name?

- ☐ Not at all
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time
- ☐ Don't Know

24.What percentage of housing costs (rent and utilities) do consumers typically pay for?

- ☐ 0 – 20%
- ☐ 21% - 39%
- ☐ 40% - 59%
- ☐ 60% - 79%
- ☐ 80% or more

Family Psycho-education

If your agency/facility provides Family Psycho-education, please answer the following questions. ***If your agency/facility does not provide Family Psycho-education, please skip to question 30.***

25. Do you provide family psycho-education using a structured curriculum?

☐ No
☐ Yes

26. (If you answered yes to question 25, which topics are typically included in your psycho-educational program? (check all that apply)

☐ Psychobiology of mental illness
☐ Diagnosis and treatment
☐ Family reaction to mental illness and its stages
☐ Psychosis as a family trauma
☐ Relapse prevention
☐ Family guidelines
☐ Recovery
☐ None of the above

27. To what extent are families taught problem solving skills?

☐ Not at all
☐ Some of the time
☐ Most of the time
☐ All of the time
☐ Don't Know

28. To what extent are families taught to identify early warning signs and symptoms of relapse?

☐ Not at all
☐ Some of the time
☐ Most of the time
☐ All of the time
☐ Don't Know

29. To what extent are families taught to identify precipitating factors that may lead to a relapse?

☐ Not at all
☐ Some of the time
☐ Most of the time
☐ All of the time
☐ Don't Know

Illness Management/Recovery

If your agency provides Illness Management/Recovery, please answer the following questions. If your agency does not provide Illness Management/Recovery services, please skip to question 32.

30. Do you provide Illness Management and Recovery (IMR) services using a structured curriculum?

- ☐ Yes
- ☐ No

31. (If yes) Which topics are typically included in the IMR curriculum? (check all that apply)

- ☐ Recovery strategies
- ☐ Practical facts about mental illness and treatment
- ☐ The stress-vulnerability model
- ☐ Building social support
- ☐ Effective use of medication
- ☐ Reducing relapse
- ☐ Coping with stress
- ☐ Coping with symptoms
- ☐ Enhancing wellness
- ☐ Other:_____

Medication Management

If your agency provides the evidence-based practice called "Medication Management", please answer the following questions. If your agency does not provide medication management services, please skip to question 36.

32. To what degree does the treatment plan specify what outcome is expected for each medication?

- ☐ Not at all
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time
- ☐ Don't Know

33. Are consumer responses to each medication recorded using standardized forms and charts?

- ☐ Not at all
- ☐ Some of the time

☐ Most of the time
☐ All of the time
☐ Don't Know

34. Are medication errors identified and tracked using standardized forms and charts?

☐ Not at all
☐ Some of the time
☐ Most of the time
☐ All of the time
☐ Don't Know

35a. Are anti-psychotic medication changes based on clinical guidelines?

☐ Not at all
☐ Some of the time
☐ Most of the time
☐ All of the time
☐ Don't Know

35b. To what extent do consumers and practitioners share in the decision making about medication management?

☐ Not at all
☐ Some of the time
☐ Most of the time
☐ All of the time
☐ Don't Know

Multi-systemic Therapy (MST)

If your agency provides Multi-systemic Therapy, please answer the following questions. (If your agency does not provide Multi-systemic Therapy services, please skip to question 42.

36. Are MST services provided by either MST therapists or Masters level professionals?

☐ No
☐ Yes

37. Are MST services available 24/7?

☐ No
☐ Yes

38. Are MST services time-limited?

☐ No

☐ Yes

39. Our MST program provides parent(s) with the resources needed for effective parenting.

☐ Not at all
☐ Some of the time
☐ Most of the time
☐ All of the time
☐ Don't Know

40. Our MST program attempts to decrease youth involvement with delinquent and drug using peers.

☐ Not at all
☐ Some of the time
☐ Most of the time
☐ All of the time
☐ Don't Know

41.Our MST program attempts to increase youth association with prosocial peers.

☐ Not at all
☐ Some of the time
☐ Most of the time
☐ All of the time
☐ Don't Know

Therapeutic Foster Care

If your agency provides Therapeutic Foster Care, please answer the following questions. (If your agency does not provide therapeutic foster care services, please skip to question 44.

42. Do foster parents receive training to work with children with emotional and behavioral disorders?

☐ Not at all
☐ Some of the time
☐ Most of the time
☐ All of the time
☐ Don't Know

43. Do foster parents receive ongoing supervision and support?

☐ Not at all
☐ Some of the time

☐ Most of the time
☐ All of the time
☐ Don't Know

Functional Family Therapy

If your agency provides Functional Family Therapy, please answer the following questions. (If your agency does not provide functional family therapy services, please skip to question 47.

44. Our functional family therapy program services are provided in phases related to engagement, motivation, assessment, behavior change, and generalization.

☐ Not at all
☐ Some of the time
☐ Most of the time
☐ All of the time
☐ Don't Know

45. On average, how many hours of direct service are children and their families provided? _____

46. Functional Family Therapy is provided in (please check all that apply):

☐ Home
☐ Clinic
☐ Juvenile court
☐ School
☐ Other community setting

Other EBPs and Best or Promising Practices:

47. Does your agency/facility provide any other emerging evidence-based practices or other promising practices (practices for which the research evidence base is still being finalized, but that appear to be very promising practices; examples may include consumer run services, etc.)?

☐ Yes
☐ No

48. If you answered Yes to question #47, please list those Emerging EBPs and other Innovative Practices provided by your agency/facility.

Emerging EBPs and Innovative Practices:
1.
2.
3.
4.
5.

CLINICAL PRACTICE GUIDELINES

In recent years, several clinical practice guidelines and/or treatment recommendations have been developed by several groups. These practice guidelines are based on research results regarding the effectiveness or efficacy of particular treatments or medications. This section of the survey gathers information regarding the use of any of the published treatment guidelines as either an official policy of your agency or as part of common, typical practice patterns.

49. Is your agency using standardized clinical guidelines and treatment recommendations?

☐ Yes
☐ No

50. If you answered yes to question 49, which of the following clinical guidelines and recommendations are being used? *(please check all that apply)*

☐ American Psychiatric Association
☐ Consensus "Tri-University" Project
☐ Schizophrenia Patient Outcome Research Team (PORT)
☐ Texas Medication Algorithm Project (TMAP)
☐ American Psychological Association
☐ Other (specify_____
☐ Other (specify)_____

51. Have any of the clinical guidelines been selected/adopted as an official agency policy for the treatment of persons with particular mental disorders?

☐ Yes

☐ No

52. If yes, for which conditions or diagnostic groups are clinical guidelines being used? *(Please check all that apply)*

☐ Mood disorders
☐ Major unipolar depression
☐ Bipolar disorder
☐ Schizophrenia
☐ Other psychotic disorder (specify): _____
☐ Dementia
☐ Alcohol abuse and dependence
☐ Other substance abuse and dependence
☐ Dual disorders (mental and addictive)
☐ Anxiety disorders
☐ Other (specify):_____

53. What is your position title in the agency/facility you work in?

_____

54. What is the name of the agency/facility you work for?

_____

Thank you for taking this survey. We appreciate your participation.

Appendix C

Responses to Individual Fidelity Questions

Table 3: Assertive Community Treatment Pilot Questions, n = 7

Item	n	%
Our ACT program emphasizes a team approach rather than an approach that emphasizes services by individual providers.		
Not at All……..	0	0
Some of the Time……..	0	0
Most of the Time…….	1	14
All of the Time…….	5	71
Don't Know……..	0	0
Missing…….	1	14
To what degree does your ACT program develop community living skills in the <u>community</u> rather than in the office.		
Not at All……..	1	14
Some of the Time……...	0	0
Most of the Time…….	3	43
All of the Time…….	2	29
Don't Know……..	0	0
Missing…….	1	14
Which of the following services are provided by your ACT team:		
Psychiatric services…….	5	71
Counseling/psychotherapy……..	5	71
Housing support…….	5	71
Substance abuse treatment……..	6	86
Employment/rehabilitative services……..	4	57
Missing…….	1	14
Which of the following staff currently work on your ACT team (check all that apply)?		
Psychiatrist……...	5	71
Nurse…….	5	71
Substance Abuse specialist……..	5	71
Vocational specialist……..	3	43
Psychologist…….	1	14
Case manager…….	6	86
Social Worker……..	2	29
Peer Support Specialist…….	1	14
Missing……..	1	14
Do you provide 12 hour responsibility for the clients on your ACT team?		
Yes…….	5	86
No…….	0	0
Missing…….	1	14
What is the average Staff to Client Ratio of your ACT team?		
1:4……...	2	29
1:10…….	2	29
1:12…….	1	14
1:15…….	1	14

Missing……..	1	14

Table 4: Supported Employment Pilot Questions, n = 13

Item	n	%
Our employment specialists provide competitive job options in normalized settings where clients work side-by-side with employees hired from the general population.		
Not at All……	0	0
Some of the Time……	2	15
Most of the Time……..	3	23
All of the Time……..	7	54
Don't Know……...	0	0
Missing……..	1	8
Our employment specialists provide job options in a variety of industries (i.e., clerical, technical, food service, etc).		
Not at All……	0	0
Some of the Time……	3	23
Most of the Time……	1	8
All of the Time……..	8	62
Don't Know……...	0	0
Missing……..	1	8
Our employment specialists attend regular treatment team meetings.		
Not at All……	0	0
Some of the Time……	2	15
Most of the Time……..	3	23
All of the Time……..	7	54
Don't Know……...	0	0
Missing……..	1	8
Our employment specialists have frequent contact with treatment team members.		
Not at All……	0	0
Some of the Time……	1	8
Most of the Time……..	3	23
All of the Time……..	8	62
Don't Know……...	0	0
Missing……..	1	8
What is the typical length of time between when a person begins the supported employment program and their first contact with an employer?		
Within 1 month……	0	0
1-6 months……	9	69

7-9 months……	3	23
10-12 months……	0	0
More than a year……..	0	0
Missing……..	1	8
What criteria, if any, are used to determine if a person is eligible for vocational services? (check all that apply)		
Job readiness……	3	23
Lack of substance abuse……..	2	15
No history of violent behavior……..	2	15
Mild psychiatric symptoms……	1	8
No criteria are used, all adult clients with severe mental disorders are eligible……..	9	69
Missing……	2	15

Table 5: Supported Housing Pilot Questions, n = 15

Item	n	%
Are specific staff assigned to provide supported housing services at your agency?		
Yes…….....	12	80
No…….	3	20
Missing……..	0	0
To what extent is your supported housing program provided to persons who would not have a viable housing arrangement without this service?		
Not at All.....	0	0
Some of the Time.....	2	13
Most of the Time.....	7	47
All of the Time.....	6	40
Don't Know.....	0	0
Missing.....	0	0
To what extent are supported housing consumers living in facilities that are integrated (i.e., the consumer is living with or around people who do not have a mental disorder):		
Not at All.....	2	13
Some of the Time.....	2	13
Most of the Time.....	7	47
All of the Time.....	4	27
Don't Know.....	0	0
Missing.....	0	0
To what extent do consumers have the ownership or lease documents of the house, apartment, or similar setting in their name?		
Not at All.....	2	13
Some of the Time.....	2	13

Most of the Time.....	7	47
All of the Time.....	4	27
Don't Know.....	0	0
Missing.....	0	0
What percentage of housing costs (rent and utilities) do consumers typically pay for?		
0 – 20%.....	3	20
21% - 39%.....	7	47
40% - 59%.....	4	27
60% - 79%.....	0	0
80% or more……..	1	7
Missing.....	0	0

Table 6: Family Psychoeducation Pilot Questions, n = 25

Item	n	%
Do you provide family psycho-education using a structured curriculum?		
Yes……	8	32
No……..	15	60
Missing……..	2	8
If you answered yes to question 25, which topics are typically included in your psycho-educational program? (check all that apply)		
Psychobiology of mental illness……	4	16
Diagnosis and treatment……	7	28
Family reaction to mental illness and its stages…….	8	32
Psychosis as a family trauma……	2	22
Relapse prevention……	4	16
Family guidelines……	8	32
Recovery……...	4	16
None of the above……...	0	0
Missing……..	16	64
To what extent are families taught problem solving skills?		
Not at All……	0	0
Some of the Time……	8	32
Most of the Time……..	9	36
All of the Time……..	6	24
Don't Know……...	0	0
Missing……..	2	8
To what extent are families taught to identify early warning signs and symptoms of relapse?		
Not at All……	0	0
Some of the Time……	4	16

Most of the Time……..	12	48
All of the Time……..	6	24
Don't Know……...	0	0
Missing……..	3	12
To what extent are families taught to identify precipitating factors that may lead to a relapse?		
Not at All……	0	0
Some of the Time……	5	20
Most of the Time……..	12	48
All of the Time……..	6	24
Don't Know……...	0	0
Missing……..	2	8

Table 7: Illness Management and Recovery Pilot Questions, n = 15

Item	n	%
Do you provide Illness Management and Recovery (IMR) services using a structured curriculum?		
Yes…….	7	47
No……..	6	40
Missing……...	2	13
(If yes) Which topics are typically included in the IMR curriculum? (check all that apply)		
Recovery strategies…….	8	53
Practical facts about mental illness and treatment…….	8	53
The stress-vulnerability model……...	6	40
Building social support……	8	53
Effective use of medication……	8	53
Reducing relapse…….	8	53
Coping with stress…….	8	53
Coping with symptoms……	8	53
Enhancing wellness…….	7	53
Other……..	2	13
Missing……..	7	7

Table 8: Medication Management Pilot Questions, n = 23

Item	n	%
To what degree does the treatment plan specify what outcome is expected for each medication?		
Not at All……	2	9
Some of the Time……	6	26
Most of the Time……..	5	22
All of the Time……..	10	44

Don't Know……..	0	0
Missing……	0	0
Are consumer responses to each medication recorded using standardized forms and charts?		
Not at All……	3	13
Some of the Time……	2	9
Most of the Time……..	4	17
All of the Time……..	11	48
Don't Know……..	2	9
Missing……	1	4
Are medication errors identified and tracked using standardized forms and charts?		
Not at All……	2	9
Some of the Time……	1	4
Most of the Time……..	2	9
All of the Time……..	12	52
Don't Know……..	3	13
Missing……	3	13
Are anti-psychotic medication changes based on clinical guidelines?		
Not at all……	0	0
Some of the time……	0	0
Most of the time……	4	17
All of the time……	11	48
Don't Know……..	5	22
Missing……..	3	13
To what extent do consumers and practitioners share in the decision making about medication management?		
Not at all……	0	0
Some of the time……	0	0
Most of the time……	9	39
All of the time……	11	48
Don't Know……..	0	0
Missing……..	3	13

Table 9: Multisystemic Therapy Items, n = 13

Item	n	%
Are MST services provided by either MST therapists or Masters level professionals?		
Yes……	12	92
No……	0	0
Missing……	1	8
Are MST services available 24/7?		
Yes……	6	46
No……	6	46
Missing……	1	8

Are MST services time-limited?		
Yes……	9	69
No……	3	23
Missing……	1	8
Our MST program provides parent(s) with the resources needed for effective parenting.		
Not at All……	0	0
Some of the Time……	2	15
Most of the Time……..	5	39
All of the Time……..	5	39
Don't Know……...	0	0
Missing……..	1	8
Our MST program attempts to decrease youth involvement with delinquent and drug using peers.		
Not at All……	0	0
Some of the Time……	1	8
Most of the Time……..	1	8
All of the Time……..	8	62
Don't Know……...	2	15
Missing……..	1	8
Our MST program attempts to increase youth association with prosocial peers.		
Not at All……	0	0
Some of the Time……	0	0
Most of the Time……..	3	23
All of the Time……..	7	54
Don't Know……...	2	15
Missing……	1	8

Table 10: Therapeutic Foster Care Pilot Questions, n = 10

Item	**n**	**%**
Do foster parents receive training to work with children with emotional and behavioral disorders?		
Not at all……..	0	0
Some of the time……...	0	0
Most of the time…….	1	10
All of the time…….	9	90
Don't Know…….	0	0
Missing……	0	0
Do foster parents receive ongoing supervision and support?		
Not at all……..	0	0
Some of the time……...	0	0
Most of the time……..	1	10
All of the time…….	9	90

Don't Know…….	0	0
Missing……	0	0

Table 11: Functional Family Therapy, n = 9

Item	n	%
Our functional family therapy program services are provided in phases related to engagement, motivation, assessment, behavior change, and generalization.		
Not at all……..	0	0
Some of the time……...	1	11
Most of the time…….	2	22
All of the time…….	6	67
Don't Know…….	0	0
Missing……	0	0
On average, how many hours of direct service are children and their families provided? _____		
0-25 hours……..	4	44
26-50 hours……	3	33
>50 hours……	1	11
Missing……	1	11
Functional Family Therapy is provided in (please check all that apply):		
Home……	9	100
Clinic…….	6	67
Juvenile court……..	3	33
School……..	5	56
Other community setting……...	5	56